PLAN OF SUPERVISION FOR CLINICAL
MARRIAGE & FAMILY THERAPIST ASSOCIATE

No Marriage and Family Therapist Associate shall begin practice or accrue supervision hours prior to contract approval by the Board. (201 KAR 32:025)

Instructions:

1. **Read the application and instructions carefully before filling out the application. Answer all questions. If the answer is "no" or "none," please indicate. If non-applicable, indicate N/A. If additional space is needed, attach separate sheets.**
2. **Must be typed or printed in legible manner.**
3. **Please include an official agency job description (If Applicable)**
4. **If experience from multiple work settings or supervision from more than one supervisor is planned, complete the following information for each.**

APPLICANT'S NAME: _____ ASSOC. PERMIT #_____

APPLICANT'S ADDRESS: _____

E-MAIL_____

CLINICAL MARRIAGE & FAMILY THERAPY SETTING

Agency Name: _____ Phone: (____) _____

Agency Address: _____
Street, PO Box, etc. City State Zip Code

Description of agency function (hospital, mental health agency, private practice, etc.): _____

Beginning Date of Plan: _____ Estimated Ending Date: _____
(Two year minimum requirement)

SUPERVISOR OF RECORD

A. Name: _____ KY LMFT # _____
(AAMFT approved supervisor or if licensed in accordance with 201 KAR 32:010, Section 1 #3 (b)

B. Address: _____
Street City State Zip Code

C. Telephone: Home: (____) _____ Office: (____) _____

CLINICAL MARRIAGE & FAMILY THERAPY SETTING

Agency Name: _____ Phone: (____) _____

Agency Address: _____
Street, PO Box, etc. City State Zip Code

Description of agency function (hospital, mental health agency, private practice, etc.): _____

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SUPERVISOR OF RECORD

A. Name: _____ KY LMFT # _____
(AAMFT approved supervisor or if licensed in accordance with 201 KAR 32:010, Section 1 #3 (b)

C. Address: _____
Street City State Zip Code

C. Telephone: Home: (____) _____ Office: (____) _____

PLAN OF MARRIAGE AND FAMILY THERAPY SUPERVISION

A. A detailed description of the nature of this work setting is (i.e. what types of activities, therapies, counseling, etc: will they be individuals, couples, groups, etc; length and duration of therapy)

_____

_____

_____

_____

_____

B. A detailed description of the nature, duration, and frequency of the supervision in this practice is: (i.e. how often and how long are supervisory sessions; what will be done in supervisory sessions; how will they be conducted)

_____

_____

_____

_____

_____

C. A detailed description of the condition or procedures for termination of this relationship is:

_____

_____

_____

D. Hours per week spent in direct client-professional relationship (Include clinical diagnosis and treatment only) _____

_____

AFFIDAVIT

I, the supervisor of record for the above named candidate for licensure for the independent practice of marriage & family therapy, have devised and discussed this plan with said applicant and accept responsibility for its implementation. Further, I understand that upon completion of the plan of supervision for marriage & family therapy experience and application for examination, I will be asked to comment on the ethical behavior and therapeutic competency acquired by the applicant. If, for any reason, the conditions of this plan are changed, or this supervisory relationship is terminated or changed, I will immediately notify the Board. Further, I do hereby certify that my license is current, and will be maintained throughout this period.

Signature of Clinical Supervisor _____ Date _____

I the applicant in the above plan, understand that I will be expected to comply with the provisions of this plan in its entirety and must notify the Board of any modifications of this plan once it has been approved by it. Failure to do so may result in voiding the approval given by the Board and loss of supervision hours gained.

Signature of Applicant _____ Date _____

AGENCY SUPERVISION

If the supervision in the Plan of Marriage & Family Therapy Supervision in this application is provided by someone other than the applicant's agency supervisor, the agency supervisor must review the proposed plan and sign the statement below:

As agency supervisor of the above named candidate, I affirm the agency will support the proposed practice experience as described.

Signature of Agency Supervisor _____ Date _____

SHARED RESPONSIBILITY

If the supervision for the activities listed in this application is to be received outside the applicant's place of employment, the section below must be completed and signed by the supervisor of record, the applicant, and an authorized person representing the agency.

We the undersigned, do hereby acknowledge the sharing of professional responsibility between

_____
(Name of Agency)

and _____ for the clinical MFT service provided to clients of the above
(Supervisor of Record)

named agency by _____ and are jointly to be held accountable for the
(Applicant)

quality of the service provided. We further acknowledge that since the supervision outlined previously will take place outside the agency of employment and that the agency cases will be used in this supervisory relationship, complete and total confidentiality of patient records will be maintained by all parties throughout the period.

_____

Signature of Supervisor of Record | License Number | Date

_____

Signature of Applicant | Permit Number | Date

_____

Signature of Agency Representative | Date